Mr. Mazzamuto is a 45-year-old restaurant owner in Pennsylvania whose medical records are presented for review for a disability claim related to coronary artery disease (CAD), and lower back pain. The date of onset of the disability is given as 7-22-00. The available medical records were reviewed, including information recently received. Mr. Mazzamuto also has a history of GERD, prostatitis, elevated lipids, smoking and a positive family history for CAD, with his father reportedly dying at age 54 of CAD, following several CVAs. Medications include Neurontin, Wellbutrin, Lopressor, Prevacid, Zocor, aspirin, Vioxx and Flexeril. He had previously been out of work for several months in 1996 related to his lower back pain.

In a claim form dated 11-22-00, Mr. Mazzamuto indicated that he had a heart condition with a recent MI and that he worked 40 hours a week, as owner and president of a restaurant with 7 fulltime and 6 part time employees, (apparently a pizza and sub restaurant with a seating capacity for 76), spending 20 hours supervising employees, 10 hours in bookkeeping and 10 hours in other office duties. He described his activities in a day as involving sitting 3.5 hours, standing 3.5 hours, and walking 1 hour, with up to 10 pounds lifting. He wrote that he "cannot perform my duties under stressful situation. My chest is painful and I am fearful for my life."

In a claim progress form dated 1-18-01, Mr. Mazzamuto wrote, "My job requires me to stand most of the time. I am always stressed which causes tightness in my chest, and then I have chest pain and shortness of breath. Also by standing my back problem is aggravated." The report of a telephone interview dated 1-4-01 indicated that Mr. Mazzamuto felt that his back was mostly what was keeping him out of work; that his duties were primarily managerial; and that he rarely helped the workers, unless they were short staffed.

In an attending physician statement (APS) dated 11-15-00, Dr. Bower, his internist, indicated that Mr. Mazzamuto had symptoms of anxiety, worry and low back pain, with restrictions of no prolonged standing, no heavy lifting, and "cannot work in stressful situations." In an accompanying letter dated 11-3-00, Dr. Bower wrote that he tried to return to work but it made his back worse, and that he had increased anxiety at work because of the stress and that he could not return to work at that time related to the restrictions from prolonged standing, heavy lifting and bending. In an APS dated 1-18-01, Dr. Bower indicated that he could not return to work related to his back problem.

Clinical Summary

With respect to his CAD, Mr. Mazzamuto was hospitalized on 7-22-00 for the new onset of angina, with CPK evidence of a small subendocardial MI. Cardiac catheterization demonstrated a 90% distal LAD stenosis, which was dilated to a 10% residual. Other stenoses included a 50% Dg1, and several 30 to 40% RCA narrowings. Ejection fraction was 55%. He was readmitted several weeks later for recurrent chest pain, which was different from the pain of his MI and felt not to be cardiac in origin. On 8-29-00, he had a stress echo test, walking for 7 minutes in the Bruce protocol (approximately 10 METs), with a peak heart rate of 115 on beta blockers, an ejection fraction of 50%, increasing with exercise, and apical akinesis, but no evidence of inducible ischemia.

In an office note on 1-11-01, Dr. Bower reported that he was doing well, and exercising without difficulty, but had continued back pain.

With respect to his lower back pain, Mr. Mazzamuto has a long history of lower back pain, which has been treated with Neurontin, NSAIDs, Flexeril and epidural steroid injections, about twice yearly. A CT scan on 9-15-92 reported spinal stenosis at the L3-4 and L4-5 level. Following a flare-up in pain after a fall on ice in 1996, an MRI on 6-5-96 again reported the spinal stenosis at L3-4, felt to be developmental in origin, with no evidence of significant DJD or disc herniation. His pain at the time was described as burning,

Exhibit B

located centrally in the lower back, extending down the lateral thighs to the knees. Although prolonged standing was said to lead to leg numbness, no abnormality on neurologic exam was reported. In an office visit on 9-22-97, he reported his back was better, but bothered him after 3 hours of standing.

His back pain reportedly increased again following hitting a bump during his ambulance ride to the hospital in July 2000. His most recent epidural injections were on 10-18-00 and 1-31-01.

Response to Questions

With respect to his CAD, Mr. Mazzamuto had a small non-q wave MI in July 2000, followed by a reportedly successful PTCA of the distal LAD, with no other flow-limiting stenoses identified. He has an ejection fraction of 50 to 55%, and performed on an exercise test in August 2000 to approximately 10 METs, without evidence of inducible ischemia. He has reported chest discomfort following the MI, in part associated with stress, which his physicians do not consider to be cardiac in origin. There is no indication of a stress-related rhythm disorder.

On the basis of the above, there is no information to support a cardiac impairment which would preclude work involving sedentary to light physical activity on a full-time (40-plus hour a week) schedule. His physician has restricted him from stressful situations, but there does not appear to be any information to support a present cardiac impairment related to stress, either terms of a significant stress-induced rhythm disorder or angina.

With respect to his back pain, Mr. Mazzamuto has a long history of lower back pain in association with a degree of spinal stenosis on MRI. In the absence of evidence of a radiculopathy on physical exam, or other studies, this appears to be soft tissue in origin. He has been maintained conservatively on medication, with occasional epidural injections. He indicates that the pain is increases with prolonged standing, and his physician has restricted him from prolonged standing or walking, heavy lifting, and bending.

His job does not appear to involve heavy lifting. The degree to which he is required to stand or walk for prolonged, uninterrupted periods of time over 15 to 20 minutes at a time is not clear. It should also be noted that lower back pain tends to wax and wane, and although he appears to have had prolonged exacerbations after episodes of trauma (slipping on ice and a bump during the ambulance ride), the discomfort has subsided in the past, at least enough to return to work, and there does not appear to have been any significant structural change in his condition associated with the recent exacerbation.

I would be happy to discuss further at any time, as well as to review this again if any questions emerge or additional information is received.

John Clarke, M.D.